

State of Michigan
Department of Civil Service
EMPLOYEE BENEFITS DIVISION
400 South Pine Street, P.O. Box 30002
Lansing, Michigan 48909

ENROLLMENT APPLICATION Health, Dental, Vision, Life, and LTD Plans																
<i>Please type or print FIRMLY with ballpoint pen.</i>										DATE OF EVENT						
EVENT <input type="checkbox"/> Record Change (Check one below) <input type="checkbox"/> New Enrollment <input type="checkbox"/> Reinstatement <input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Ineligible Dependent <input type="checkbox"/> Other (Explain) Reason:																
SECTION A – APPLICANT DATA																
EMPLOYEE ID NO.		EMPLOYEE LAST NAME			FIRST NAME			M.I.	ARE YOU OR YOUR SPOUSE ENROLLED IN MEDICARE?		EMPLOYEE <input type="checkbox"/> YES <input type="checkbox"/> NO SPOUSE <input type="checkbox"/> YES <input type="checkbox"/> NO					
SECTION B – COVERAGE DATA																
HEALTH	<input type="checkbox"/> State Health Plan	<input type="checkbox"/> HMO	<input type="checkbox"/> Catastrophic Plan		<input type="checkbox"/> Opt Out	<input type="checkbox"/> Decline Coverage	<input type="checkbox"/> E – Employee Only	<input type="checkbox"/> S – Employee & Spouse	<input type="checkbox"/> C – Employee & Children	<input type="checkbox"/> F – Full Family						
DENTAL	<input type="checkbox"/> State Dental Plan	<input type="checkbox"/> DMO	<input type="checkbox"/> Preventive Dental Plan			<input type="checkbox"/> Decline Coverage	<input type="checkbox"/> E – Employee Only	<input type="checkbox"/> S – Employee & Spouse	<input type="checkbox"/> C – Employee & Children	<input type="checkbox"/> F – Full Family						
VISION	<input type="checkbox"/> State Vision Plan					<input type="checkbox"/> Decline Coverage	<input type="checkbox"/> E – Employee Only	<input type="checkbox"/> S – Employee & Spouse	<input type="checkbox"/> C – Employee & Children	<input type="checkbox"/> F – Full Family						
LIFE	<input type="checkbox"/> Reduced Life (One times annual salary to maximum of \$50,000) <input type="checkbox"/> Regular Life (Two times annual salary to a maximum of \$200,000*) *This life insurance limit may not be applicable to employees who are covered by a collective bargaining agreement.					Dependent Life Coverage <input type="checkbox"/> F – Spouse \$1,500 and/or Child(ren) \$1,000 <input type="checkbox"/> G – Spouse \$5,000 and/or Child(ren) \$2,500 <input type="checkbox"/> H – Spouse \$10,000 and/or Child(ren) \$5,000 <input type="checkbox"/> K – Spouse \$25,000 and/or Child(ren) \$10,000 <input type="checkbox"/> L – Child(ren) \$10,000										
LTD	<input type="checkbox"/> Elect Coverage		<input type="checkbox"/> Decline Coverage			<input type="checkbox"/> I have read and understand the conditions under which long-term disability can be paid.										
IF HMO, PROVIDE NAME OF HMO & CODE FROM NEW HIRE BENEFIT ELECTION FORM						IF DMO, PROVIDE DENTAL CENTER CHOICE FROM NEXT PAGE OF FORM										
SECTION C – DEPENDENT ENROLLMENT DATA (Attach additional pages, if necessary.)																
ADD	DEL	NAME		LAST		FIRST		M.I.	SOCIAL SECURITY NUMBER		RELATION TO YOU	SEX M/F	DATE OF BIRTH (MM/DD/YYYY)	COVERAGE (Y/N)		
														HEALTH	DENTAL	VISION
<input type="checkbox"/>	<input type="checkbox"/>	SPOUSE														
<input type="checkbox"/>	<input type="checkbox"/>	DEPENDENT														
<input type="checkbox"/>	<input type="checkbox"/>	DEPENDENT														
<input type="checkbox"/>	<input type="checkbox"/>	DEPENDENT														
<input type="checkbox"/>	<input type="checkbox"/>	DEPENDENT														
<input type="checkbox"/>	<input type="checkbox"/>	DEPENDENT														
I have read and agree to the applicable terms and conditions stated on the reverse side of this application		SIGNATURE OF APPLICANT										DATE				

IF THIS IS AN APPLICATION FOR COVERAGE:

- I certify that the information provided on the front of this application is correct to the best of my information, knowledge, and belief.
- I elect to enroll in the state-sponsored Health, Dental, Vision, Life, and/or LTD Plan(s) for which I am eligible, as checked on the front of this application. I understand that this application authorizes the State of Michigan to withhold the contribution(s) required for my enrollment(s).
- I understand that I may enroll my legal spouse (with copy of marriage certificate), and unmarried children under age 19 (with copy of official birth certificate, not hospital birth certificate) or up to age 25 who are enrolled in an accredited educational institution (with copy of school registration or other records proving school attendance). Eligible children include my child by birth, legal adoption, or legal guardianship; foster children placed in my home by a state agency or a court; and step-children for whom I have physical custody (i.e. live with me at least 50% of the time as stated in a current divorce decree and for whom I provide at least 50% of their support).
- I also understand that coverage(s) which are already in place for my unmarried child will not be terminated at age 19 and over if the child is totally incapacitated, unable to earn a living because of mental or physical disabilities, and depends chiefly on me for support and maintenance, and that coverage(s) are not terminated for any other reason. Proof that your child is incapacitated must be submitted before age 19 to your health plan administrator or to the Employee Benefits Division.
- I agree to give notice of any changes in my status and status of my family members that effect eligibility. If I acquire a new eligible dependent, plan enrollment must be made either in 31 days of this event (with copy of official birth certificate, not hospital birth certificate, if newborn, marriage certificate, if new spouse, or adoption papers, if newly adopted child), or during an open enrollment period.
- I understand that no one may be insured as both an employee/retiree AND as a dependent under these state-sponsored plans; nor may two employees/retirees independently insure the same dependent(s) under state-sponsored plans.
- I authorize the Plan Administrator to obtain from providers of service any and all records and information relating to me and my family members. I understand that this information may also be reviewed by the State of Michigan.

IF I HAVE DECLINED COVERAGE ON THE FRONT OF THIS APPLICATION:

- I understand that I have been offered enrollment in the state-sponsored Health, Dental, Vision, Life, and/or LTD Plan(s), but have declined coverage in one or all of the plans at this time, as I have indicated on the front of this application.

IF I AM MAKING A RECORD CHANGE ON THE FRONT OF THIS APPLICATION:

- I certify that the information provided on the front of this application, as it relates to the membership change I've requested, is correct to the best of my information, knowledge, and belief.

OTHER:

- Addresses for dependents can be provided to your Human Resources Office, if different than yours.
- Check with your Human Resources Office for information regarding continuation of coverage for your dependents in the event they become ineligible.

AUTHORIZED DMO DENTAL CENTERS (Choose one center)

CANTON, MI
DEARBORN, MI
DETROIT, MI
LANSING, MI
STERLING HEIGHTS, MI
WARREN, MI
WOODHAVEN, MI